		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003020

Facility Name: MENARD CONVALESCENT CENTER

Address: 120 W. ANTLE (Number) PETERSBURG (City) 62675 (Zip Code)

County: MENARD

Telephone Number: 217-632-2249 **Fax #** 217-632-2314

IDPA ID Number: 37-0856151001

Date of Initial License for Current Owners: 12/1/66

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217-787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/01 to 11/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	59	Skilled (SNF)	59	21,535	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,785	1,785	8
9	SNF/PED					9
10	ICF	12,840	3,853		16,693	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,840	3,853	1,785	18,478	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.87%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
OUTSIDE NON-PATIENT MEALS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 1,785

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/02 Fiscal Year: 11/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	84,100	11,954	4,528	100,582		100,582		100,582			1
2	Food Purchase		67,368		67,368		67,368	(20,599)	46,769			2
3	Housekeeping	28,478	9,174		37,652		37,652		37,652			3
4	Laundry	15,593	8,817		24,410		24,410		24,410			4
5	Heat and Other Utilities			49,097	49,097		49,097		49,097			5
6	Maintenance	28,657	16,982	26,279	71,918		71,918	803	72,721			6
7	Other (specify):* Utility Workers	33,835			33,835		33,835		33,835			7
8	**TOTAL General Services**	190,663	114,295	79,904	384,862		384,862	(19,796)	365,066			8
	B. Health Care and Programs											
9	Medical Director	12,033		6,000	18,033		18,033		18,033			9
10	Nursing and Medical Records	610,932	88,651	116,893	816,476	(58,972)	757,504	3,311	760,815			10
10a	Therapy	19,958	1,447	167,186	188,591	(167,186)	21,405		21,405			10a
11	Activities	32,000	2,400		34,400		34,400		34,400			11
12	Social Services	5,831		3,783	9,614		9,614		9,614			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	680,754	92,498	293,862	1,067,114	(226,158)	840,956	3,311	844,267			16
	C. General Administration											
17	Administrative	32,427		7,227	39,654	1,300	40,954	23,638	64,592			17
18	Directors Fees											18
19	Professional Services			119,433	119,433		119,433	(112,294)	7,139			19
20	Dues, Fees, Subscriptions & Promotions			4,815	4,815		4,815	(975)	3,840			20
21	Clerical & General Office Expenses	22,482	7,791	4,561	34,834		34,834	15,630	50,464			21
22	Employee Benefits & Payroll Taxes			153,037	153,037		153,037	9,783	162,820			22
23	Inservice Training & Education			1,283	1,283		1,283	434	1,717			23
24	Travel and Seminar			3,299	3,299	(2,911)	388	289	677			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			105,820	105,820		105,820	243	106,063			26
27	Other (specify):*			15,712	15,712		15,712	(15,712)				27
28	**TOTAL General Administration**	54,909	7,791	415,187	477,887	(1,611)	476,276	(78,964)	397,312			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	926,326	214,584	788,953	1,929,863	(227,769)	1,702,094	(95,449)	1,606,645			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MENARD CONVALESCENT CENTER #0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation					18,547	18,547	3,799	22,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			13,818	13,818		13,818		13,818			33
34	Rent-Facility & Grounds							2,836	2,836			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Depreciation			18,547	18,547	(18,547)						36
37	**TOTAL Ownership**			32,365	32,365		32,365	6,635	39,000			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					227,769	227,769		227,769			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			47,085	47,085	227,769	274,854		274,854			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	926,326	214,584	868,403	2,009,313		2,009,313	(88,814)	1,920,499			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,054)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,832	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(943)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,773)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(521)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,939)	27		24
25	Fund Raising, Advertising and Promotional	(709)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(286)	20		28
29	Other-Attach Schedule VENDING	(2,545)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,938)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(52,876)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (52,876)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (88,814)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		167,186	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		451	10	42
43	Prescription Drugs	X		43,934	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Oxygen	X		15,440	10	45
46	Other-Attach Schedule Med Supp	X		758	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 227,769		47

STATE OF ILLINOIS

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/01

Ending: 11/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18,054)	0	0	0	0	0	0	0	0	0	0	(18,054)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,054)	0	0	0	0	0	0	0	0	0	0	(18,054)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	130	0	0	0	0	0	0	0	0	0	130	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(521)	(112,299)	0	0	0	0	0	0	0	0	0	(112,820)	19
20	Fees, Subscriptions & Promotions	(995)	0	0	0	0	0	0	0	0	0	0	(995)	20
21	Clerical & General Office Expenses	(943)	0	0	0	0	0	0	0	0	0	0	(943)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(130)	0	0	0	0	0	0	0	0	0	(130)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(15,712)	0	0	0	0	0	0	0	0	0	0	(15,712)	27
28	**TOTAL General Administration**	(18,171)	(112,299)	0	0	0	0	0	0	0	0	0	(130,470)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,225)	(112,299)	0	0	0	0	0	0	0	0	0	(148,524)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,832	0	0	0	0	0	0	0	0	0	0	2,832	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,832	0	0	0	0	0	0	0	0	0	0	2,832	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,393)	(112,299)	0	0	0	0	0	0	0	0	0	(145,692)	45

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN ESTATE	25.00	D'ADRIAN CONVALESCENT CENTER	GODFREY	Nursing Home Mngr	SPRINGFIELD	MANAGEMENT
H. RAYMOND KLEIN	25.00	HILLTOP NURSING HOME	CHARLESTON			
ROBERT SCHAFER	25.00	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE			
BARRY FREE	25.00	MEADOW MANOR	TAYLORVILLE			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 118,647	NURSING HOME MANAGERS	50.00%	$	$ (118,647)	1
2	V	VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS		59,423	59,423	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		6,348	6,348	3
4	V	24	TRAVEL	130	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(130)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		130	130	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 118,777			$ 65,901	$ * (52,876)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00					$ 1,416	17-7	1
2	ROBERT SCHAFER	MED. DIRECTOR	MED. DIRECTOR	25.00		6	12.00		12,033	9-1	2
3											3
4											4
5											5
6			H. Raymond Klein was paid by Nursing Home Managers, Inc., a related								6
7			organization. Total compensation of $10472 was allocated among the								7
8			six related nursing homes, based upon 10 hours per week.								8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,449		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 W. LAWRENCE, SUITE B.
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	12,562	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	13,764	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,202	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	12,616	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	13,818	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	13,496	8
	1998	13,488	9
	1999	13,870	10
	2000	13,705	11
	2001	13,764	12

LINE 4 ACCRUAL 11/12 x $13764 = $12616

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MENARD CONVALESCENT CENTER COUNTY MENARD

FACILITY IDPH LICENSE NUMBER 0003020

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-219-006	MENARD CONVALESCENT CTR	$ 97.02	$ 97.02
2.	11-14-219-009	MENARD CONVALESCENT CTR	$ 527.88	$ 527.88
3.	11-14-227-001	MENARD CONVALESCENT CTR	$ 825.60	$ 825.60
4.	11-14-228-001	MENARD CONVALESCENT CTR	$ 11,510.94	$ 11,510.94
5.	11-14-228-002	MENARD CONVALESCENT CTR	$ 494.52	$ 494.52
6.	11-14-229-001	MENARD CONVALESCENT CTR	$ 307.92	$ 307.92
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,763.88	$ 13,763.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,211 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	93,436	1993-1994	$ 9,919	1
2					2
3	TOTALS	93,436		$ 9,919	3

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1966	1966	$ 172,985	$ 1,397	30	$	$ (1,397)	$ 172,985	4
5	32		1974	1974	148,705	1,754	30		(1,754)	148,705	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1966	5,308					5,308	9
10	FIRE DOORS			1979	1,433					1,433	10
11	FIRE DOORS			1981	8,340					8,340	11
12	BATHROOM			1984	7,335	132	30	244	112	4,531	12
13	AIR CONDITIONER			1984	1,100	22	8		(22)	1,100	13
14	ELECTRICAL & PLUMBING			1985	11,117	471	15		(471)	11,117	14
15	PLUMBING			1986	4,921	207	15		(207)	4,921	15
16	SMOKE DETECTORS			1986	10,445	439	25	418	(21)	6,897	16
17	AIR CONDITIONER			1986	2,235	94	10		(94)	2,235	17
18	PLUMBING			1986	1,145	48	20	57	9	941	18
19	ROOF			1987	6,362	233	20	318	85	4,929	19
20	WATER HEATER & WINDOWS			1988	6,530	207	15	380	173	6,530	20
21	NURSE CALL			1988	1,674	53	10		(53)	1,674	21
22	ROOF			1989	30,672	974	20	1,534	560	20,708	22
23	WATER HEATER & PARKING LOT			1989	11,502	365	15	767	402	10,354	23
24	FURNACE & FLOORING			1990	19,165	608	15	1,278	670	15,974	24
25	AIR CONDITIONER			1991	2,633	84	15	175	91	2,023	25
26	PLUMBING FAUCETS			1992	8,909	283	15	594	311	6,237	26
27	DOOR ALARM			1992	1,572	50	20	78	28	946	27
28	WATER HEATER & GARAGE DOOR			1993	4,348	138	15	290	152	2,755	28
29	WATER HEATER & PLUMBING			1994	5,074	130	15	339	209	2,874	29
30	LANDSCAPING			1994	3,900	260	15	260		2,145	30
31	AIR CONDITIONER & ROOF			1995	7,049	181	15	470	289	3,525	31
32	REMODEL BATHROOMS- TILE, CEILING, FIXTURES			1996	19,751	506	15	1,317	811	8,560	32
33	AIR CONDITIONER			1997	1,710	44	15	114	70	627	33
34	FIRE DAMPERS			1998	4,076	105	15	271	166	1,223	34
35	FURNACE			1998	2,200	56	15	146	90	660	35
36	GREASE TRAP			1999	2,824	72	15	189	117	659	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CEILING REPAIR	2002	$ 4,935	$ 111	15	$ 302	$ 191	$ 302	37
38	AIR CONDITIONING	2002	2,102	6	15	23	17	23	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 522,057	$ 9,030		$ 9,564	$ 534	$ 461,241	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 118,674	$ 7,933	$ 10,904	$ 2,971	VAR	$ 70,241	71
72	Current Year Purchases	10,687	1,584	911	(673)	VAR	911	72
73	Fully Depreciated Assets	138,283					138,283	73
74		(73,230)					(73,230)	74
75	TOTALS	$ 194,414	$ 9,517	$ 11,815	$ 2,298		$ 136,205	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 726,390	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,547	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,379	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,832	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 597,446	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-8	hrs	$	1,998	$ 86,683	$	1,998	$ 86,683	1
2	Licensed Speech and Language Development Therapist	39-8	hrs		172	8,244		172	8,244	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs		1,414	72,259		1,414	72,259	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				43,934		43,934	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxy., Labs, MC Supp	39-8					16,649		16,649	13
14	TOTAL			$	3,584	$ 167,186	$ 60,583	3,584	$ 227,769	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/01 **Ending:** 11/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,506	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	392,682		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,078		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 407,266	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	522,057		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	263,190		16
17	Accumulated Depreciation (book methods)	(656,128)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 139,038	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 546,304	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 188,293	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,403		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,825		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,616		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 245,137	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 245,137	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 301,167	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 546,304	$	48

***(See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 515,414	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 515,414	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(194,247)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(20,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (214,247)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 301,167	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,694,955	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,694,955	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,086	6
7	Oxygen	120	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 97,206	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,192	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,192	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending 2545 Exp Reimb 18054 Admit Fees 780	21,379	28
28a	W/A 46 Old checks 117 Flu Shots 170 Dep Error 1	334	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,713	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,815,066	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	384,862	31
32	Health Care	1,067,114	32
33	General Administration	477,887	33
	B. Capital Expense		
34	Ownership	32,365	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,009,313	40
41	**Income before Income Taxes (line 30 minus line 40)****	(194,247)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (194,247)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,120	2,160	$ 45,295	$ 20.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,782	3,946	75,563	19.15	3
4	Licensed Practical Nurses	11,439	12,362	172,926	13.99	4
5	Nurse Aides & Orderlies	37,672	38,839	317,148	8.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,978	2,128	19,958	9.38	8
9	Activity Director	1,713	1,793	13,400	7.47	9
10	Activity Assistants	2,736	2,850	18,600	6.53	10
11	Social Service Workers	732	751	5,831	7.76	11
12	Dietician					12
13	Food Service Supervisor	1,986	2,141	23,227	10.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,151	9,378	60,873	6.49	15
16	Dishwashers					16
17	Maintenance Workers	3,683	3,815	28,657	7.51	17
18	Housekeepers	4,761	4,842	28,478	5.88	18
19	Laundry	2,469	2,508	15,593	6.22	19
20	Administrator	1,280	1,480	32,427	21.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,004	2,124	22,482	10.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	300	300	12,033	40.11	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	6,138	6,226	33,835	5.43	33
34	TOTAL (lines 1 - 33)	93,944	97,643	$ 926,326 *	$ 9.49	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	147	$ 4,528	1-3	35
36	Medical Director	100	6,000	9-3	36
37	Medical Records Consultant	17	528	10-3	37
38	Nurse Consultant	791	32,824	10-3	38
39	Pharmacist Consultant	48	774	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	66	3,783	13-3	45
46	Other(specify)				46
47	ADMINISTRATIVE CONSULTANT	248	7,227	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,415	$ 55,664		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	137	$ 5,491	10-3	50
51	Licensed Practical Nurses	2,207	63,474	10-3	51
52	Nurse Aides	722	13,802	10-3	52
53	TOTAL (lines 50 - 52)	3,066	$ 82,767		53

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEVEN TERRITO	ADMINISTRATOR	0	$ 3,447
SARA BACHMANN	ADMINISTRATOR	0	25,130
JULIA SMITH	ADMINISTRATOR	0	3,850
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 32,427

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 7,227
TOTAL (agree to Schedule V, line 17, col. 3)	$ 7,227
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT FEE	$ 118,647
CSC	CORP. REPRESENTATION	265
Feldman, Wasser, Draper, et al	LEGAL	521
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 119,433

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,647
Unemployment Compensation Insurance	7,531
FICA Taxes	69,509
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE CAFETERIA PLAN	35,895
EMPLOYEE LIFE INSURANCE	2,074
HOLIDAY PARTY	450
GIFT CERTIFICATES	853
VACCINES	1,078
NHM ALLOCATION	9,783
TOTAL (agree to Schedule V, line 22, col.8)	$ 162,820

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HOLIDAY PARTY	22	$ 450
GIFT CERTIFICATES	22	853
VACCINES	22	1,078
TOTAL		$ 2,381

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,542
Health Care Worker Background Check	648
(Indicate # of checks performed 54)	
YELLOW PAGES/PUBLIC RELATIONS	995
FOOD LICENSE	100
ADMINISTRATOR LICENSE	75
HCFA LAB FEE	150
FRANCHISE FEE	105
NHM ALLOCATION	20
Less: Public Relations Expense	(709)
Non-allowable advertising	( )
Yellow page advertising	(286)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,840

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISC. MILEAGE REIMBURSEMENT	388
NHM ALLOCATION	289
Seminar Expense	
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 677

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING	6/90	$ 1,471	3 YRS	$	$	$	$	$	$	$	$	$
2	PAINTING	7/91	1,450	3 YRS									
3	PAINTING	7/94	2,726	3 YRS									
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,647		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MENARD CONVALESCENT CENTER **#** 0003020 **Report Period Beginning:** 12/1/01 **Ending:** 11/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **164** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **47,085**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **18,054**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V

PAGE 3 LINE 27 COLUMN 3
OTHER COSTS

SALES TAX	$	1,773
BAD DEBT		13,939
	$	15,712

COLUMN 5 RECLASSIFICATIONS

			LINE #
RECLASS FROM:			
FLU SHOTS	$	(170)	10
LABS		(451)	10
MEDICARE DRUGS		(43,764)	10
MEDICARE SUPPLIES		(758)	10
OXYGEN		(15,440)	10
PHYSICAL THERAPY		(72,259)	10A
SPEECH THERAPY		(8,244)	10A
OCCUPATIONAL THERAPY		(86,683)	10A
RECLASS TO: ANCILLARY	$	227,769	
RECLASS TO:			
NURSE CONSULTANT TRAVEL	$	1,611	10
ADMINISTRATIVE CONS. TRAVEL		1,300	17
RECLASS FROM: TRAVEL	$	(2,911)	24

SCHEDULE XI

PAGE 13 SECTION E
RECONCILIATION OF DEPRECIATION

LINE 83	$	21,379
NURSING HOME MANAGERS ALLOCATION		967
SCHEDULE V LINE 30 COLUMN 8	$	22,346

PAGE 23 QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED
BASED UPON TIME CARDS

SCHEDULE XVII PAGE 19 LINE 41
RECONCILIATION OF INCOME

NET INCOME	$ (194,247)
* ACCRUED MANAGEMENT FEE 11/01	(13,621)
* ACCRUED MANAGEMENT FEE 11/02	8,967
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(1,192)
	$ (200,093)

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS

SCHEDULE VII - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
MENARD
2001

	DEC 01	JAN 02	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2001 TOTAL	LINE #
SALARIES-ADMIN	$1,937	$1,759	$1,939	$1,977	$1,910	$1,868	$1,824	$1,917	$1,709	$1,710	$1,780	$1,763	$22,092	17
SALARIES-CLERIC	1,069	1,180	1,301	1,327	1,282	1,254	1,224	1,287	1,236	1,237	1,288	1,275	14,959	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	10	371	409	417	403	394	385	405	127	127	132	131	3,311	10
ACCOUNTING	5	45	49	50	48	47	46	49	46	46	48	47	526	19
WORK COMP INS	17	10	11	12	11	11	11	11	17	17	17	17	162	22
SUPPLIES	8	62	68	70	67	66	64	68	103	103	107	106	893	21
TELEPHONE	40	54	59	60	58	57	56	59	68	68	71	70	721	21
EMPL BENEFITS	416	506	558	569	550	538	525	552	641	642	668	662	6,827	22
PAYROLL TAXES	180	233	256	261	253	247	241	253	213	214	222	220	2,794	22
TRAVEL	35	37	40	41	40	39	38	40	27	27	28	28	419	24
IN SERVICE	4	21	24	24	23	23	22	23	66	66	69	68	434	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	11	12	13	13	13	13	12	13	12	12	13	13	151	6
OWNERS COMP	161	108	119	121	117	114	112	117	110	110	115	113	1,416	17
INS-PROP,LIAB,WC	24	26	29	29	28	28	27	28	6	6	6	6	243	26
DEPRECIATION	86	88	97	99	95	93	91	96	54	54	57	56	967	30
RENT	213	227	250	255	246	241	235	247	226	226	235	233	2,836	34
MAINTENANCE	62	51	57	58	56	55	53	56	50	50	52	52	652	6
FEES & PUBLICAT	10	0	0	0	0	0	0	0	0	0	0	0	10	20
ADVERTISING		0	0	0	0	0	0	0	2	2	3	3	10	20
		0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$4,291	$4,789	$5,280	$5,384	$5,202	$5,086	$4,966	$5,222	$4,714	$4,718	$4,912	$4,864	$59,423	
FIXED ASSETS													59,423	
EQUIP - PRIOR	7,797	7,459	8,224	8,386	8,102	7,922	7,735	8,133	7,426	7,432	7,737	7,662	7,834	
EQUIP - CURR	443	0	0	0	0	0	0	751	686	686	715	708	332	
EQUIP - FULLY DEP	1,118	2,491	2,746	2,800	2,705	2,645	2,583	2,715	2,479	2,482	2,583	2,558	2,492	
BLDG - PRIOR	825	877	967	986	953	932	910	957	873	874	910	901	914	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MENARD CONVALESCENT CENTER #0003020 12/01/01 to 11/30/02 PAGE 27

MONTHLY CENTRAL OFFICE COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.34%	13.65%	21.83%	15.93%	12.27%	20.98%	100.00%
SALARIES-ADMIN	$2,422	$2,155	$3,447	$2,515	$1,937	$3,312	$15,787
SALARIES-CLERIC	1,336	1,189	1,902	1,387	1,069	1,827	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	11	17	12	10	16	78
ACCOUNTING	7	6	9	7	5	9	43
WORK COMP INS	21	18	30	22	17	28	135
SUPPLIES	10	9	14	11	8	14	66
TELEPHONE	50	44	71	52	40	68	325
EMPL BENEFITS	520	463	740	540	416	711	3,389
PAYROLL TAXES	225	200	320	234	180	308	1,468
TRAVEL	43	38	61	45	35	59	282
IN SERVICE	5	4	7	5	4	7	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	12	20	15	11	19	91
OWNERS COMP	201	179	286	209	161	275	1,309
INS-PROP,LIAB,WC	30	26	42	31	24	40	192
DEPRECIATION	108	96	153	112	86	147	702
RENT	267	237	380	277	213	365	1,739
MAINTENANCE	77	69	110	80	62	106	505
FEES & PUBLIC	13	11	18	13	10	17	82
ADVERTISING	6	5	9	6	5	8	40
	0	0	0	0	0	0	0
TOTAL	$5,366	$4,774	$7,637	$5,571	$4,291	$7,338	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,750	8,675	13,876	10,123	7,797	13,333	63,553
EQUIP - CURR	553	492	788	575	443	757	3,607
EQUIP - FULLY DEP	1,398	1,244	1,989	1,451	1,118	1,911	9,111
BLDG - PRIOR	1,032	918	1,468	1,071	825	1,411	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.72%	13.85%	21.27%	15.29%	13.05%	20.82%	100.00%
SALARIES-ADMIN	$2,119	$1,868	$2,867	$2,061	$1,759	$2,807	$13,480
SALARIES-CLERIC	1,423	1,253	1,924	1,383	1,180	1,884	$9,048
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	447	394	605	435	371	592	$2,844
ACCOUNTING	54	47	73	52	45	71	$342
WORK COMP INS	13	11	17	12	10	17	$80
SUPPLIES	75	66	101	73	62	99	$475
TELEPHONE	65	57	88	63	54	86	$412
EMPL BENEFITS	610	538	825	593	506	808	$3,881
PAYROLL TAXES	280	247	379	272	233	371	$1,782
TRAVEL	44	39	60	43	37	58	$280
IN SERVICE	26	23	35	25	21	34	$164
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	14	13	19	14	12	19	$91
OWNERS COMP	130	114	175	126	108	172	$825
INS-PROP,LIAB,WC	31	28	43	31	26	42	$200
DEPRECIATION	106	93	143	103	88	140	$673
RENT	273	241	370	266	227	362	$1,739
MAINTENANCE	62	55	84	60	51	82	$395
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,772	$5,086	$7,808	$5,612	$4,789	$7,645	$36,712
FIXED ASSETS							
EQUIP - PRIOR	8,990	7,921	12,160	8,741	7,459	11,907	57,179
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	3,002	2,645	4,060	2,919	2,491	3,976	19,092
BLDG - PRIOR	1,057	932	1,430	1,028	877	1,400	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.05%	13.91%	21.15%	15.04%	14.38%	20.46%	100.00%
SALARIES-ADMIN	$2,029	$1,875	$2,852	$2,028	$1,939	$2,758	$13,480
SALARIES-CLERIC	1,362	1,259	1,914	1,361	1,301	1,851	$9,048
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	428	396	602	428	409	582	$2,844
ACCOUNTING	51	48	72	51	49	70	$342
WORK COMP INS	12	11	17	12	11	16	$80
SUPPLIES	71	66	100	71	68	97	$475
TELEPHONE	62	57	87	62	59	84	$412
EMPL BENEFITS	584	540	821	584	558	794	$3,881
PAYROLL TAXES	268	248	377	268	256	365	$1,782
TRAVEL	42	39	59	42	40	57	$280
IN SERVICE	25	23	35	25	24	34	$164
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	14	13	19	14	13	19	$91
OWNERS COMP	124	115	175	124	119	169	$825
INS-PROP,LIAB,WC	30	28	42	30	29	41	$200
DEPRECIATION	101	94	142	101	97	138	$673
RENT	262	242	368	262	250	356	$1,739
MAINTENANCE	59	55	84	59	57	81	$395
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,526	$5,107	$7,766	$5,522	$5,280	$7,510	$36,712
FIXED ASSETS							
EQUIP - PRIOR	8,606	7,955	12,096	8,601	8,224	11,698	57,179
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	2,874	2,656	4,039	2,872	2,746	3,906	19,092
BLDG - PRIOR	1,012	936	1,423	1,012	967	1,376	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.31%	13.91%	21.64%	14.35%	14.67%	20.12%	100.00%
SALARIES-ADMIN	$2,064	$1,875	$2,918	$1,934	$1,977	$2,713	$13,480
SALARIES-CLERIC	1,386	1,258	1,958	1,298	1,327	1,821	$9,048
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	436	396	616	408	417	572	$2,844
ACCOUNTING	52	48	74	49	50	69	$342
WORK COMP INS	12	11	17	11	12	16	$80
SUPPLIES	73	66	103	68	70	96	$475
TELEPHONE	63	57	89	59	60	83	$412
EMPL BENEFITS	594	540	840	557	569	781	$3,881
PAYROLL TAXES	273	248	386	256	261	359	$1,782
TRAVEL	43	39	61	40	41	56	$280
IN SERVICE	25	23	36	24	24	33	$164
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	14	13	20	13	13	18	$91
OWNERS COMP	126	115	179	118	121	166	$825
INS-PROP,LIAB,WC	31	28	43	29	29	40	$200
DEPRECIATION	103	94	146	97	99	135	$673
RENT	266	242	376	250	255	350	$1,739
MAINTENANCE	60	55	85	57	58	79	$395
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,622	$5,105	$7,946	$5,267	$5,384	$7,388	$36,712
FIXED ASSETS							
EQUIP - PRIOR	8,756	7,951	12,376	8,203	8,386	11,507	57,179
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	2,924	2,655	4,132	2,739	2,800	3,842	19,092
BLDG - PRIOR	1,030	935	1,456	965	986	1,353	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.75%	14.45%	21.28%	14.32%	14.17%	20.04%	100.00%
SALARIES-ADMIN	$2,123	$1,948	$2,868	$1,930	$1,910	$2,701	$13,480
SALARIES-CLERIC	1,425	1,307	1,925	1,296	1,282	1,813	$9,048
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	448	411	605	407	403	570	$2,844
ACCOUNTING	54	49	73	49	48	69	$342
WORK COMP INS	13	11	17	11	11	16	$80
SUPPLIES	75	69	101	68	67	95	$475
TELEPHONE	65	59	88	59	58	82	$412
EMPL BENEFITS	611	561	826	556	550	778	$3,881
PAYROLL TAXES	281	258	379	255	253	357	$1,782
TRAVEL	44	41	60	40	40	56	$280
IN SERVICE	26	24	35	24	23	33	$164
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	14	13	19	13	13	18	$91
OWNERS COMP	130	119	176	118	117	165	$825
INS-PROP,LIAB,WC	32	29	43	29	28	40	$200
DEPRECIATION	106	97	143	96	95	135	$673
RENT	274	251	370	249	246	348	$1,739
MAINTENANCE	62	57	84	57	56	79	$395
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,782	$5,305	$7,811	$5,257	$5,202	$7,356	$36,712
FIXED ASSETS							
EQUIP - PRIOR	9,006	8,262	12,165	8,187	8,102	11,457	57,179
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	3,007	2,759	4,062	2,734	2,705	3,825	19,092
BLDG - PRIOR	1,059	972	1,431	963	953	1,347	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	16.49%	12.92%	20.98%	14.97%	13.85%	20.79%	100.00%
SALARIES-ADMIN	$2,222	$1,742	$2,828	$2,018	$1,868	$2,803	$13,480
SALARIES-CLERIC	1,492	1,169	1,898	1,354	1,254	1,881	$9,048
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	469	368	597	426	394	591	$2,844
ACCOUNTING	56	44	72	51	47	71	$342
WORK COMP INS	13	10	17	12	11	17	$80
SUPPLIES	78	61	100	71	66	99	$475
TELEPHONE	68	53	86	62	57	86	$412
EMPL BENEFITS	640	501	814	581	538	807	$3,881
PAYROLL TAXES	294	230	374	267	247	371	$1,782
TRAVEL	46	36	59	42	39	58	$280
IN SERVICE	27	21	34	25	23	34	$164
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	15	12	19	14	13	19	$91
OWNERS COMP	136	107	173	123	114	172	$825
INS-PROP,LIAB,WC	33	26	42	30	28	42	$200
DEPRECIATION	111	87	141	101	93	140	$673
RENT	287	225	365	260	241	362	$1,739
MAINTENANCE	65	51	83	59	55	82	$395
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,053	$4,744	$7,700	$5,495	$5,086	$7,634	$36,712
FIXED ASSETS							
EQUIP - PRIOR	9,427	7,389	11,994	8,558	7,922	11,890	57,179
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	3,148	2,467	4,005	2,858	2,645	3,970	19,092
BLDG - PRIOR	1,109	869	1,411	1,007	932	1,398	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	16.01%	13.36%	20.56%	15.68%	13.53%	20.87%	100.00%
SALARIES-ADMIN	$2,158	$1,801	$2,772	$2,113	$1,824	$2,813	$13,480
SALARIES-CLERIC	1,448	1,209	1,861	1,418	1,224	1,888	9,048
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	455	380	585	446	385	594	2,844
ACCOUNTING	55	46	70	54	46	71	342
WORK COMP INS	13	11	16	12	11	17	80
SUPPLIES	76	63	98	74	64	99	475
TELEPHONE	66	55	85	65	56	86	412
EMPL BENEFITS	621	518	798	608	525	810	3,881
PAYROLL TAXES	285	238	367	279	241	372	1,782
TRAVEL	45	37	58	44	38	58	280
IN SERVICE	26	22	34	26	22	34	164
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	15	12	19	14	12	19	91
OWNERS COMP	132	110	170	129	112	172	825
INS-PROP,LIAB,WC	32	27	41	31	27	42	200
DEPRECIATION	108	90	138	106	91	140	673
RENT	278	232	358	273	235	363	1,739
MAINTENANCE	63	53	81	62	53	82	395
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,876	$4,904	$7,549	$5,755	$4,966	$7,661	$36,712
FIXED ASSETS							
EQUIP - PRIOR	9,153	7,638	11,758	8,964	7,735	11,931	57,179
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	3,056	2,550	3,926	2,993	2,583	3,984	19,092
BLDG - PRIOR	1,076	898	1,383	1,054	910	1,403	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	14.75%	14.18%	20.68%	15.42%	14.22%	20.76%	100.00%
SALARIES-ADMIN	$1,988	$1,911	$2,787	$2,078	$1,917	$2,798	$13,480
SALARIES-CLERIC	1,334	1,283	1,871	1,395	1,287	1,878	9,048
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	420	403	588	438	405	590	2,844
ACCOUNTING	50	48	71	53	49	71	342
WORK COMP INS	12	11	16	12	11	17	80
SUPPLIES	70	67	98	73	68	99	475
TELEPHONE	61	58	85	63	59	85	412
EMPL BENEFITS	572	550	802	598	552	805	3,881
PAYROLL TAXES	263	253	369	275	253	370	1,782
TRAVEL	41	40	58	43	40	58	280
IN SERVICE	24	23	34	25	23	34	164
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	13	19	14	13	19	91
OWNERS COMP	122	117	171	127	117	171	825
INS-PROP,LIAB,WC	30	28	41	31	28	42	200
DEPRECIATION	99	95	139	104	96	140	673
RENT	257	247	360	268	247	361	1,739
MAINTENANCE	58	56	82	61	56	82	395
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,415	$5,205	$7,591	$5,659	$5,222	$7,620	$36,712
FIXED ASSETS							
EQUIP - PRIOR	8,433	8,108	11,823	8,815	8,133	11,868	57,179
EQUIP - CURR	779	749	1,092	814	751	1,096	5,281
EQUIP - FULLY DEP	2,816	2,707	3,948	2,943	2,715	3,963	19,092
BLDG - PRIOR	992	954	1,391	1,037	957	1,396	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	14.05%	13.99%	22.07%	16.09%	12.99%	20.82%	100.00%
SALARIES-ADMIN	$1,849	$1,840	$2,904	$2,117	$1,709	$2,739	$13,158
SALARIES-CLERIC	1,337	1,331	2,100	1,531	1,236	1,981	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	137	137	216	157	127	204	978
ACCOUNTING	49	49	78	57	46	73	352
WORK COMP INS	18	18	28	21	17	27	128
SUPPLIES	111	111	175	128	103	165	794
TELEPHONE	74	73	116	85	68	109	525
EMPL BENEFITS	694	691	1,090	794	641	1,028	4,938
PAYROLL TAXES	231	230	363	264	213	342	1,644
TRAVEL	29	29	46	33	27	43	208
IN SERVICE	72	71	113	82	66	106	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	13	21	15	12	20	95
OWNERS COMP	119	118	187	136	110	176	847
INS-PROP,LIAB,WC	6	6	10	7	6	9	45
DEPRECIATION	59	59	92	67	54	87	419
RENT	244	243	384	280	226	362	1,739
MAINTENANCE	54	54	85	62	50	80	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	3	3	4	3	2	4	19
	0	0	0	0	0	0	0
TOTAL	$5,100	$5,077	$8,012	$5,839	$4,714	$7,558	$36,300
FIXED ASSETS							
EQUIP - PRIOR	8,033	7,998	12,620	9,198	7,426	11,905	57,179
EQUIP - CURR	742	739	1,166	850	686	1,100	5,281
EQUIP - FULLY DEP	2,682	2,670	4,214	3,071	2,479	3,975	19,092
BLDG - PRIOR	945	941	1,484	1,082	873	1,400	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	13.70%	14.53%	21.89%	16.16%	13.00%	20.71%	100.00%
SALARIES-ADMIN	$1,803	$1,912	$2,881	$2,127	$1,710	$2,725	$13,158
SALARIES-CLERIC	1,304	1,383	2,084	1,538	1,237	1,971	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	134	142	214	158	127	203	978
ACCOUNTING	48	51	77	57	46	73	352
WORK COMP INS	18	19	28	21	17	27	128
SUPPLIES	109	115	174	128	103	164	794
TELEPHONE	72	76	115	85	68	109	525
EMPL BENEFITS	677	718	1,081	798	642	1,023	4,938
PAYROLL TAXES	225	239	360	266	214	340	1,644
TRAVEL	28	30	45	34	27	43	208
IN SERVICE	70	74	112	82	66	106	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	14	21	15	12	20	95
OWNERS COMP	116	123	185	137	110	175	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	57	61	92	68	54	87	419
RENT	238	253	381	281	226	360	1,739
MAINTENANCE	53	56	84	62	50	80	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	3	3	4	3	2	4	19
	0	0	0	0	0	0	0
TOTAL	$4,975	$5,275	$7,947	$5,868	$4,718	$7,517	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,836	8,309	12,518	9,243	7,432	11,841	57,179
EQUIP - CURR	724	767	1,156	854	686	1,094	5,281
EQUIP - FULLY DEP	2,617	2,774	4,180	3,086	2,482	3,954	19,092
BLDG - PRIOR	922	977	1,472	1,087	874	1,393	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	12.95%	15.00%	21.53%	16.58%	13.53%	20.41%	100.00%
SALARIES-ADMIN	$1,704	$1,973	$2,833	$2,182	$1,780	$2,685	$13,158
SALARIES-CLERIC	1,233	1,427	2,049	1,578	1,288	1,942	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	127	147	211	162	132	200	978
ACCOUNTING	46	53	76	58	48	72	352
WORK COMP INS	17	19	28	21	17	26	128
SUPPLIES	103	119	171	132	107	162	794
TELEPHONE	68	79	113	87	71	107	525
EMPL BENEFITS	640	741	1,063	819	668	1,008	4,938
PAYROLL TAXES	213	247	354	273	222	335	1,644
TRAVEL	27	31	45	34	28	42	208
IN SERVICE	66	76	110	85	69	104	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	12	14	20	16	13	19	95
OWNERS COMP	110	127	182	140	115	173	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	54	63	90	69	57	86	419
RENT	225	261	374	288	235	355	1,739
MAINTENANCE	50	58	83	64	52	78	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	2	3	4	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$4,702	$5,444	$7,815	$6,019	$4,912	$7,408	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,407	8,575	12,310	9,481	7,737	11,669	57,179
EQUIP - CURR	684	792	1,137	876	715	1,078	5,281
EQUIP - FULLY DEP	2,473	2,863	4,110	3,166	2,583	3,896	19,092
BLDG - PRIOR	871	1,008	1,448	1,115	910	1,372	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	12.31%	15.51%	22.10%	16.54%	13.40%	20.14%	100.00%
SALARIES-ADMIN	$1,619	$2,041	$2,908	$2,176	$1,763	$2,650	$13,158
SALARIES-CLERIC	1,171	1,476	2,104	1,574	1,275	1,917	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	120	152	216	162	131	197	978
ACCOUNTING	43	55	78	58	47	71	352
WORK COMP INS	16	20	28	21	17	26	128
SUPPLIES	98	123	175	131	106	160	794
TELEPHONE	65	82	116	87	70	106	525
EMPL BENEFITS	608	766	1,092	817	662	995	4,938
PAYROLL TAXES	202	255	363	272	220	331	1,644
TRAVEL	26	32	46	34	28	42	208
IN SERVICE	63	79	113	84	68	103	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	12	15	21	16	13	19	95
OWNERS COMP	104	131	187	140	113	171	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	52	65	93	69	56	84	419
RENT	214	270	384	288	233	350	1,739
MAINTENANCE	47	60	85	64	52	77	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	2	3	4	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$4,468	$5,632	$8,024	$6,003	$4,864	$7,311	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,037	8,871	12,639	9,455	7,662	11,515	57,179
EQUIP - CURR	650	819	1,167	873	708	1,064	5,281
EQUIP - FULLY DEP	2,350	2,962	4,220	3,157	2,558	3,845	19,092
BLDG - PRIOR	828	1,043	1,486	1,112	901	1,354	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES
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OCCUPIED

DAYS 2001	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112
FEBRUAR	2,100	1,570	2,067	1,408	518	1,538	1,875	11,076
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209
JULY	2,114	1,602	2,434	2,119	0	1,702	2,441	12,412
AUGUST	1,947	1,692	2,387	2,112	0	1,697	2,317	12,152
SEPTEM	1,768	1,761	2,359	2,027	0	1,652	2,193	11,760
OCTOBER	1,815	1,800	2,546	2,012	0	1,548	2,354	12,075
NOVEMBE	1,733	1,731	2,510	1,897	0	1,432	2,325	11,628
DECEMBE	1,777	1,581	2,529	1,845	0	1,421	2,430	11,583
TOTAL	24,358	20,011	28,400	21,342	3,078	19,155	27,702	144,046
								144,046

OCCUPIED

DAYS 2002	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,809	1,594	2,447	1,759		1,501	2,396	11,506
FEBRUAR	1,598	1,477	2,246	1,597		1,527	2,172	10,617
MARCH	1,773	1,610	2,506	1,661		1,698	2,330	11,578
APRIL	1,793	1,645	2,422	1,630		1,613	2,281	11,384
MAY	1,910	1,497	2,430	1,734		1,605	2,409	11,585
JUNE	1,795	1,498	2,306	1,758		1,517	2,340	11,214
JULY	1,682	1,617	2,358	1,758		1,622	2,367	11,404
AUGUST	1,573	1,566	2,471	1,801		1,454	2,331	11,196
SEPTEM	1,493	1,583	2,385	1,761		1,416	2,256	10,894
OCTOBER	1,503	1,740	2,498	1,924		1,570	2,368	11,603
NOVEMBE	1,397	1,761	2,509	1,877		1,521	2,286	11,351
DECEMBE	464	1,783	2,501	1,844		1,525	2,371	10,488
TOTAL	18,790	19,371	29,079	21,104	0	18,569	27,907	134,820
								134,820

ALLOCATION

PERCENTAGE 2001	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
FEBRUARY	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
MARCH	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
APRIL	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
MAY	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
JUNE	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
JULY	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
AUGUST	16.02%	13.92%	19.64%	17.38%	13.96%	19.07%	100.00%
SEPTEMBER	15.03%	14.97%	20.06%	17.24%	14.05%	18.65%	100.00%
OCTOBER	15.03%	14.91%	21.08%	16.66%	12.82%	19.49%	100.00%
NOVEMBER	14.90%	14.89%	21.59%	16.31%	12.32%	19.99%	100.00%
DECEMBER	15.34%	13.65%	21.83%	15.93%	12.27%	20.98%	100.00%

ALLOCATION

PERCENTAGE 2002	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	15.72%	13.85%	21.27%	15.29%	13.05%	20.82%	100.00%
FEBRUARY	15.05%	13.91%	21.15%	15.04%	14.38%	20.46%	100.00%
MARCH	15.31%	13.91%	21.64%	14.35%	14.67%	20.12%	100.00%
APRIL	15.75%	14.45%	21.28%	14.32%	14.17%	20.04%	100.00%
MAY	16.49%	12.92%	20.98%	14.97%	13.85%	20.79%	100.00%
JUNE	16.01%	13.36%	20.56%	15.68%	13.53%	20.87%	100.00%
JULY	14.75%	14.18%	20.68%	15.42%	14.22%	20.76%	100.00%
AUGUST	14.05%	13.99%	22.07%	16.09%	12.99%	20.82%	100.00%
SEPTEMBER	13.70%	14.53%	21.89%	16.16%	13.00%	20.71%	100.00%
OCTOBER	12.95%	15.00%	21.53%	16.58%	13.53%	20.41%	100.00%
NOVEMBER	12.31%	15.51%	22.10%	16.54%	13.40%	20.14%	100.00%
DECEMBER	4.42%	17.00%	23.85%	17.58%	14.54%	22.61%	100.00%